Kentucky Board of Nursing 312 Whittington Pky, Suite 300

Telephone: 502-429-3300

or 800-305-2042

Louisville, KY 40222-5172

Instructions for the ARNP Registration Application

The Kentucky Nursing Laws (KRS 314.042) defines the advanced registered nurse practitioner (ARNP) as an individual registered and designated to engage in advanced registered nursing practice including, but not limited to, the nurse anesthetist, nurse midwife, nurse practitioner, and clinical nurse specialist. Registration is required to practice as an ARNP in Kentucky. If you practice as an ARNP in Kentucky without registration, you will be subject to disciplinary action. Practice inconsistent with the specialty standards of your certifying body may also be subject to disciplinary action. No nurse shall indicate by practice or words that he/she is an ARNP unless so registered by KBN.

All applicants for ARNP registration must complete a post-basic educational program that meets the requirements stated in 201 KAR 20:056, *ARNP Registration, Programming Requirements, Recognition of a National Certifying Organization.* Note: Some educational programs preparing clinical nurse specialists do not meet the requirements. Your transcript will be reviewed to validate the requirements have been met.

All applicants for ARNP registration must have a current, active Kentucky nursing license or temporary work permit and have completed an organized post-basic program of study and clinical practice. The program must be approved by the appropriate national certification organization.

Application fees and requirements are subject to change. Application fees are non-refundable. The current application fee is \$120, payable by check or money order, and is valid for a period of one year from the date the application is received in the KBN office. Boxes are provided on this instruction sheet for you to mark those areas of the application that you have completed.

Applicants for registration as an ARNP are required to complete the following sections:

Complete Sections

All Applicants 1, 2, 3, 4, 6 Reinstatement 1, 2, 3, 4, 5, 6

| 1, 2, 3, 4, 0 |
|---|
| Section 1: Biographical Data |
| Using black ink and capital letters, clearly print your name, address, and all other information requested. If the name on your application differs from your name on any other documents submitted with this application, you must include a copy of legal name change documentation with this application. You are required to notify the KBN office of any subsequent legal name and/or address change within 30 days. |
| Section 2: Designation/Type and Method of Application |
| Darken the circle to indicate the appropriate ARNP designation type. |
| Section 3: ARNP Educational Program Information |
| Please answer all questions in this section. If your ARNP designation is a clinical specialist or a nurse practitioner, select the type(s) that applies to you. If your designation type is not listed, write the type on the line provided. |
| Section 4: National Certification or Recertification |
| To be eligible for registration as an ARNP, you must hold a national certification/recertification OR have made application and be eligible to take an initial certification examination. |
| If you hold a current advanced nursing practice certification with a national organization, please answer "yes," insert the month and year the certification expires, and indicate the organization from which you received the certification. If the organization is not listed, write the organization's name on the line provided. YOU MUST INCLUDE A COPY OF THE CERTIFICATION WITH THIS APPLICATION. |
| If you do NOT hold a current certification, answer "no," insert the month and year you will be taking the certification examination and indicate the organization from which you will receive the certification. If the organization is not listed, write the name of the organization to which you have applied. See next page. |

| Section 4: National Certification or Recertification (continued) |
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| If you do NOT hold current certification but have applied for national certification, you must complete the following forms: |
| Verification of Eligibility and Application for Certification Examination Send this form to the national certifying organization to which you have applied and request that they submit it directly to the KBN office. |
| Verification of Supervision Complete the top portion of the form and give it to your employer and request that it be mailed directly to the KBN office. |
| TEMPORARY AUTHORIZATION TO PRACTICE |
| Upon submission of the required application documents, a temporary authorization to practice may be issued to those applicants who have registered for the certification examination. A temporary authorization is NOT available to those who have allowed a previous ARNP registration to lapse or those who have not applied to take a national certification examination. |
| ─ Section 5: Reinstatement of a Kentucky ARNP Registration ———————————————————————————————————— |
| Complete this section ONLY if you held an advanced registered nurse registration in Kentucky, the registration expired, and you wish to become registered in Kentucky again. |
| A COPY OF YOUR CURRENT NATIONAL CERTIFICATION/RECERTIFICATION MUST BE SUBMITTED WITH THIS APPLICATION. |
| ☐ Section 6: Notary ———————————————————————————————————— |
| All applications must be notarized. Do not sign the application until you are in the presence of a Notary Public. Read this section carefully as you are held legally responsible for the truthfulness and validity of the information you provide on this application. |
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| Photograph Attach a passport photograph in the space provided. The photograph must be taken no more than six months prior tot the date the application is notarized. Print your name on the back of the photograph in case the photograph should become separated from the application. |
| Additional General Requirements |
| NAME CHANGE: Legal documentation of name change if documents are in different names. |
| |
| TRANSCRIPTS: Transcripts sent directly from the school/program to the Kentucky Board of Nursing are required for all ARNP applicants. |
| (1) ARNPs applying for reinstatement, and(2) Nurse anesthetists: If your program awarded a diploma or certificate, you must send a copy of that document to KBN. |
| COLLABORATIVE PRACTICE AGREEMENT: An ARNP with a Collaborative Practice Agreement for prescriptive authority must maintain a copy of the agreement. Do NOT send a copy to KBN unless you are requested to do so. |

Kentucky Board of Nursing 312 Whittington Pky, Suite 300 Louis ville, KY 40222-5172 502-429-3300 or 800-305-2042 Internet: http://kbn.ky.gov

APPLICATION FOR REGISTRATION AS AN ADVANCED REGISTERED NURSE PRACTITIONER

| - Office Use Only | \neg |
|-------------------|--------|
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| | |

APPLICATION FEE IS NON-REFUNDABLE

Print clearly using capital letters and black ink. Refer to instruction sheet before completing this application.

| Section 1. Biographical Data | | | |
|--|--|------------------------|-----------------------------|
| Last Name: | | | Male: |
| First | | M.I.: | Female: |
| Name: Maiden Maiden | | | |
| Name: | | | |
| Street Line 1: | | | |
| Line 2: | | | |
| City: | | | State: |
| Zip: | County of Residence: | | |
| SS #: | Daytime | Phone #: | |
| Date of Birth: | Home Pt | one #: | |
| | | | |
| Section 2: Designation/Type If you seek licensure as an RN and regis | • | <u>-</u> | nnlication for each Darken |
| the circle below for the appropriate ARNP re | the state of the s | | ppircation for each. Darken |
| ARNP Specialty Type: Anesthetist (Cd A3) | Midwife (Cd M4) | Practitioner (Cd P5) | Clinical Specialist (Cd S6) |
| Section 3: ARNP Educational | Program Informa | ation ——— | |
| Please answer the following question | • | | Office Use Only |
| program you attended. See the instru | | | PON Code: |
| Advanced Practice Nursing Program Inf | ormation: (Name of Sch | ool) | |
| Name: | | | |
| City: | | | State: |
| Month & Year Entered: | М | onth & Year Graduated: | |
| Did program include a supervised clinical pr | acticum? Yes | No Degree/Cred | ential Earned: |
| Office Use Only | | | |
| TWP Dates: To: | | | RN Status Code: |
| Approved for Registration: On | By | | |

| RNP Application: Page 2 of 3 | | | Social | Security#: | | - |] - |
|--|--------------|---------------------------------|-----------|-----------------|--------------|----------------|-----------------|
| Section 3: ARNP Education | onal Pro | gram Info | ormat | ion (con | tinued |) ——— | |
| Advanced Practice Program Type: | Anes | sthetist (Cd 1) | \circ | Midw | ife (Cd 2) | 0 | |
| Clinical Specialist | S | Select Type | | Nurse Pra | actitioner | 0 | Select Type |
| Adult Psychiatric/Mental Health | (Cd 10) | \circ | | Acute Care | Э | (Cd 14) | \circ |
| Child/Adolescent Mental Health | (Cd 11) | \bigcirc | | Adult | | (Cd 3) | \bigcirc |
| Community Health | (Cd 15) | \bigcirc | | Family | | (Cd 4) | \circ |
| Gerentological | (Cd 13) | \bigcirc | | Gerentolog | gical | (Cd 7) | \circ |
| Medical/Surgical | (Cd 9) | \bigcirc | | Neonatal | | (Cd 12) | \circ |
| Other (List) | | | | Pediatric | | (Cd 5) | \bigcirc |
| | | | | School | | (Cd 8) | \bigcirc |
| | | | | Women's I | Health | (Cd 6) | \bigcirc |
| | | | | Other (List |) | | |
| Do you hold an advanced nursing prace If yes, month and year your certific (Attach a copy of the certificate with the control of the certificate with t | cation/recer | rtification expir lication.) | es: | | | No (| Yes No |
| If yes, month and year you will be | taking the | certification ex | aminati | on: |] - 🔲 | | |
| Indicate the organization from which ye | ou hold adv | anced nursing | practic | e certification | n or to whic | ch you have a | ipplied: |
| American Academy of Nurse Practit | ioners (| National C | ertificat | ion Board of F | Pediatric Nu | rse Practition | ers & Nurses (|
| American Nurses' Credentialing Ce | nter (| American | College | of Nurse-Mic | lwives | | |
| National Certification Corporation | (| American | Associ | ation of Nurse | Anestheti | sts | (|
| Other (List) | | | | | | | |
| Section 5: Reinstatemer | on only if y | ou were pre | viously | registered | as an AR | NP in the Co | ommonwealth |
| Kentucky. You must enclose: 1) a Section 4, and 2) the \$120 application | | our most red | ent na | tional certif | ication fo | rm an orgai | nization listed |
| Has your national certification ever bee | en revoked | or issued on a | provision | onal/condition | nal status? | Yes | ○ No ○ |
| If yes, you must submit an accom | npanying let | ter of explanat | ion. | | | | |

| ARNP Application: Page 3 of 3 | Social Security #: |
|---|--|
| $ar{}$ Section 6: Notary - All Applications Must Be | e Notarized ———————————————————————————————————— |
| I certify that I am the person referred to in the foreg registered nurse practitioner in the Commonwealth of photograph; that all statements contained herein and respect; that I have read and understand this applicat understand that all information on this application is falsification of any information contained herein will be | of Kentucky and who is pictured in the enclosed on all attachments are true and correct in every ion and all requirements stated therein. I further subject to an audit for verification and that the |
| ┌─ Signature of Applicant | Subscribed and sworn to before me by |
| ┌ Signature of Notary Public | on this date: |
| Oignature of Notary Fublic | State of My Commission Expires |
| | SEAL |

Make check or money order payable to: Kentucky Board of Nursing

\$120 FEE IS NOT REFUNDABLE AND IS SUBJECT TO CHANGE

If all requirements for registration are not met within the time period required by regulation, a new application must be submitted with the required fee.

- Passport Photograph —

This space to contain a recent passport photograph.

Picture must fit in this area.

Only passport photos will be accepted.

Tape photo in this section.

Print your name on the back of your photo.

VERIFICATION OF SUPERVISION FOR ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) APPLICANT

| To the Applicant ———————————————————————————————————— | |
|---|---|
| and then forward this form to the applicable employer/facilit | oyed must complete this form. Provide the information below, y with a letter requesting its completion. THE EMPLOYER MUST THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING |
| ARNP Applicant's Last Name: | ARNP Applicant's First Name: |
| | |
| Practitioner Type - Designated Nurse: Anesthetist | Practitioner |
| Employing Facility: | |
| Facility's Address: | |
| City: | State: Zip: |
| Facility's Phone #: | Employed From (Month/Year): - |
| Employment Position: | |
| | |
| | BELOW THIS LINE BE COMPLETED BY THE EMPLOYING FACILITY |
| To the Employer | |
| DIRECTLY TO THE "ARNP UNIT" AT THE KENTUCKY B FORM. This form verifies that the ARNP applicant listed registered nurse practitioner of the same specialty area | oard of Nursing Address Listed on the mail this form oard of Nursing Address Listed on the top of the above will be practicing under the supervision* of an advanced of a licensed physician until the results of the certification ding such supervision must sign this form in the spaces |
| | odic observation and evaluation of the applicant's practice to validate standards. The supervisor shall be immediately available either on |
| I hereby agree to provide the required supervision to the abo | ve named applicant for ARNP registration: |
| Supervising ARNP | Supervising Physician |
| | |
| Signature Date | Signature Date |

Space for additional signatures is provided on the attached sheet, if needed.

| Supervising ARMP — | | Supervising Physician — | |
|--------------------|--------|-------------------------|----------|
| gnature | | Signature | |
| gnature | Bate | Oignature | Dute |
| Y RN License # | ARNP # | KY License # | |
| Supervising ARNP — | | Supervising Physician — | |
| Signature | Date | Signature | Date |
| (Y RN License # | ARNP# | KY License # | |
| Supervising ARNP - | | Supervising Physician — | |
| Signature | Date | Signature | Date |
| KY RN License # | ARNP# | KY License # | |
| Supervising ARNP — | | Supervising Physician | |
| signature | Date | Signature | Date |
| KY RN License # | ARNP # | KY License # | |
| Supervising ARNP — | | Supervising Physician — | |
| Signature | Date | Signature | Date |
| | | KY License # | |

VERIFICATION OF ELIGIBILITY AND APPLICATION FOR CERTIFICATION EXAMINATION

Please disregard if currently certified by a national organization for advanced nursing practice.

| - To the Candidate |
|--|
| This verification form must be completed by the appropriate national certifying organization. Contact the certifying organization regarding any fees that may be required for this service. Forward this form to the applicable organization with a letter requesting its completion. THE NATIONAL ORGANIZATION MUST DIRECTLY MAIL THIS FORM TO THE ATTENTION OF THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING ADDRESS PROVIDED ON THE TOP OF THE FORM. |
| Certification Examination Candidate's Last Name: Certification Examination Candidate's First Name: |
| |
| Type of Advanced Practice - Designated Nurse: Anesthetist Practitioner Midwife Clinical Specialist |
| National Certifying Organization: |
| Please release my test results to the Kentucky Board of Nursing. |
| Signature — Date: |
| |
| DO NOT WRITE BELOW THIS LINE INFORMATION BELOW THIS LINE IS TO BE COMPLETED BY THE NATIONAL CERTIFYING ORGANIZATION |
| |
| To the National Certifying Organization |
| Complete this portion of the Verification of Eligibility and Application for Certification Examination form, and then MAIL THIS FORM DIRECTLY TO THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING ADDRESS LISTED ON THE TOP OF THE FORM. If questions, call 502-429-3329. |
| Examination Information |
| ○ First-Time Candidate or ○ Repeat Candidate |
| Scheduled to Take Exam Or Exam Taken Date of Exam: |
| ─ Verification Statement ─ |
| Verification Statement |
| This is to verify that the candidate listed above has met eligibility requirements and has applied to take the examination for certification for advanced practice. |
| SEAL |
| Name: |
| Title: |
| |
| Organization's Phone #: Ext: |
| Organization's Phone #: |